

Pharmacy Provider Manual



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ND Medicaid Reference Sheet

Quick Hints

- [DUR Override Codes \(Page 17\)](#):
 - Early Refill: er, m0, 1b
 - Reported Diagnosis-Drug Interaction Conflict Code: MC
 - Underutilization (Late Refill): LR
- [One Dispensing Fee Per Month Override \(Page 18\)](#): Clarification Code of 5
- [Compound Ingredient Override \(Page 12\)](#): Submission Clarification Code of 08

Provider Manuals

- [Provider Guidelines, Manuals, and Policies](#)
- [Pharmacy Medical Billing Manual](#)
- [Payer Sheet](#): NCPDP specifications for online claims processing

Medicaid Pharmacy Websites

- [Pharmacy Prior Authorization and Coverage Guidance Website](#):
- [Medicaid Pharmacy Provider Website](#):

Medicaid General Websites

- [Durable Medical Equipment Providers Website](#)
- [Medicaid Expansion Website](#)
- [Children's Health Insurance Program](#)
- [Ryan White/AIDS Drug Assistance Program](#)
- [Special Health Services](#)

State Directory

Pharmacy Program Inquiries

Brendan Joyce, PharmD, R.Ph.
Administrator, Pharmacy and Clinical
Services

Medical Services Division

Phone: 1-701-328-4023

medicaidpharmacy@nd.gov

Pharmacy Claims Inquiries

Phone: 1-701-328-4086

Fax: 1-701-328-1544 Attn: Pharmacy

medicaidpharmacy@nd.gov

Medical Claims – Traditional Medicaid

Eligibility Inquiries

Phone: 1-701-328-7098

Phone: 1-877-328-7098

mmisinfo@nd.gov

Medical Claims - Medicaid Expansion

(BCBS ND)

Phone: 1-833-777-5779

Medicaid Fraud Inquiries

Phone: 1-701-328-4024

Phone: 1-800-755-2604

medicaidfraud@nd.gov

Coordinated Services Program

Phone: 1-701-328-2346

Phone: 1-800-755-2604

MedicaidCSP@nd.gov

Eligibility Verification Line

Phone: 1-877-328-7098

Phone: 701-328-7098

POS State Network Communications

ITD Support Center

Phone: 1-701-328-4470

Phone: 1-877-328-4470

POS Switch Companies Network

(See Page 20)

RelayHealth Help Desk 1-800-401-5973

eRx Network Help Desk 1-866-379-6389

Third Party Liability

(Private Insurance/Medicare)

Phone: 1-701-328-2347

Phone: 1-800-755-2604

medicaidtpl@nd.gov

Provider Enrollment

Phone: 1-701-277-6999

Fax: 701-433-5956

NDMedicaidEnrollment@noridian.com

Special Health Services (SHS)

Phone: 1-701-328-2436

Fax: 701-328-1645

dohcshsadm@nd.gov

AIDS Drugs Assistance Program (ADAP)

Ryan White Part B Coordinator

Phone: 1-701-328-2379

Fax: 1-701-328-0338

gmathern@nd.gov

Durable Medical Equipment

Phone: 1-701-328-2764

State Address

Department of Health and Human Services

600 E Boulevard Ave, Dept 325

Bismarck ND 58505-0250

Introduction

All Medicaid (traditional and expansion) pharmacy claims as well as Special Health Services (SHS), AIDS Drug Assistance Program (ADAP), Russell Silver Program, and some county jail claims are processed by the ND Medicaid pharmacy system.

A variety of federal laws outline program requirements with the most significant being:

1. [Social Security Act §1927 \(ssa.gov\)](https://www.ssa.gov)
2. [Federal Register: Medicaid Program; Covered Outpatient Drugs](#)

Pharmacy Services Program Requirements

1. [Reimbursement of Drugs \(Page 18\)](#):
 1. Federal Upper Limit (FUL): [Federal Upper Limit | Medicaid](#)
 2. NADAC: [Methodology for Calculating the National Average Drug Acquisition Cost \(NADAC\) for Medicaid Covered Outpatient Drugs](#)
 3. Maximum Allowable Cost (MAC) program
2. [Covered Outpatient Drug \(COD\) Status \(Page 12\)](#)
3. [Manufacturer/Labeler Drug Rebate Program \(Page 13\)](#)
4. [Prospective/Retrospective Drug Utilization Review \(Page 14\)](#)
5. [Professional Dispensing Fee \(Page 18\)](#)
6. The quantity of medication dispensed shall not exceed a 34-day supply unless:
 1. Member has primary insurance
 2. The medication is packaged as a unit of use which lasts beyond 34 days
 3. The medication is low-cost maintenance medication where 90 days is allowed.
7. Provider numbers (pharmacy and prescriber) must be NPIs

Unique Characteristics to POS System

1. All claims submitted are processed in real time and will be either paid or denied. Paid claims may also be reversed by the submitting pharmacy.
2. Eligibility - POS billing confirms the member's Medicaid eligibility on the date the prescription is dispensed. It is not required to make a separate call to the member eligibility verification system ([VERIFY – Page 30](#)) because the POS system uses the same source of information as VERIFY. If the member is ineligible on the dispensing date, the claim will be denied.
3. [Recipient Liability \(Page 20\)](#)
4. [Third party Liability \(Page 21\)](#)
5. [Prospective Drug Utilization Review \(Page 15\)](#)
6. POS System Availability - The North Dakota Medicaid POS system is scheduled to be available 24 hours a day, seven days a week except for maintenance.
7. Network Processing Difficulties - The POS system is accessed via one of the pharmacy claims networks connected with North Dakota Medicaid. At times, the switch network system may be out of service or unable to exchange information with the state's system. If the condition persists, please contact the network's help desk directly for assistance.

RelayHealth Help Desk 1-800-401-5973

eRx Help Desk 1-866-379-6389

If one of these conditions persists more than 20 minutes, record the message you received and contact:

ITD Support Center

1-701-328-4470

1-877-328-4470

Instructions for Point-Of-Sale (POS) Billing

North Dakota Medicaid only accepts electronic claims submitted via POS or claims entered by providers through our [web portal](#). Pharmacies submitting via POS must submit claims in the National Council for Prescription Drug Programs (NCPDP) version D.0 format.

General Tips for Billing

1. Always bill your usual and customary charge to the general public for each prescription.
 - a. All discounts the member would be eligible to receive (e.g., discounts for age, occupation, or received by payment of a nominal membership fee) are to be reduced from the usual and customary charges before billing Medicaid.
 - b. Providers are required to use their actual acquisition cost plus the professional dispensing fee as their usual and customary for Federal Supply Schedule and 340B purchased drugs. Actual acquisition cost means 340B ceiling price for any 340B drugs where the upfront cost does not include the 340B discount but is later provided as a rebate to the provider.
2. Metric decimal quantities should be used per NCPDP guidelines.
3. The NDC dispensed must be the NDC billed to ND Medicaid.
4. All services require a prescription order from an enrolled prescriber, including over-the-counter products.
5. Timely Filing: All initial claims must be submitted within 365 days from the date of dispensing of the prescription. All adjustments must be submitted within 365 days of the remittance advice date of the paid prescription.
6. Use ND Medicaid's websites to find information regarding payment rules:
[Prior Authorization and Drug Use Review Board Website from Acentra Health](#)
[State Medicaid Pharmacy Website](#)
[Health and Humans Services Website](#)
7. North Dakota Medicaid uses a variety of payment parameters that may result in a rejected claim. Please use the [Guidance for Point-of-Sale Rejections](#) to navigate these rejection messages

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Provider Requirements

To prescribe or dispense drugs for coverage by the Medicaid program, a provider must have a valid state license and be an enrolled provider with the state Medicaid program. The provider must also have a valid DEA license to prescribe or dispense controlled substances.

These requirements are verified during claims processing. If the required licenses and enrollment are not on file for both the prescriber and pharmacy, the claim will not be covered. Valid DEA and state licenses can be provided by fax to the pharmacy claims team at 701-328-1544 to update the state license file for drug coverage.

To comply with the Federal Covered Outpatient Drugs Final Rule (CMS-2345-FC), ND Medicaid must occasionally conduct a Cost of Dispensing Survey. Pharmacies must participate in Cost of Dispensing Surveys.

Provider Enrollment

Please reference the following for detailed information:

[Provider Guidelines, Manuals, and Policies](#)

[Medicaid Provider Enrollment Information](#)

For provider enrollment inquiries:

Noridian Healthcare Solutions
Attn: ND Medicaid Provider Enrollment
PO Box 6055
Fargo, ND 58108-6055

Email: NDMedicaidEnrollment@noridian.com

Phone: (701) 277-6999

Fax: (701) 433-5956

Out of State Pharmacies

Pharmacies that are out of state (defined as physically located outside of North Dakota and the three bordering states - MT, SD, MN) must fill out a prior authorization to justify the reason that the service is not available in-state. Drugs that have limited distribution and are known to only be available out of state do not require prior authorization to be filled by an out of state pharmacy.

Please notify pharmacy claims if a drug only available out of state is rejecting for prior authorization due to out of state pharmacy dispensing so the system can be updated.

Drug Coverage

Coverage Requirements

Federal law requires that ND Medicaid cover all FDA approved drug products made by manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS), except as indicated in the non-covered services, limited coverage, and covered outpatient drug status categories described below.

Non-Covered Services

The following are not covered by the Medicaid program:

1. Drugs determined to be less-than-effective (COD status of 5 or 6)
2. Drugs made by manufacturers which have a labeler code not included in a rebate agreement with CMS.
3. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered unless the contract pharmacy is only considered a contract pharmacy due to the ND pharmacy ownership law and an agreement has been reached between the provider and ND Medicaid.
4. Cost of shipping or delivering a drug
5. Drugs which coverage is limited or excluded by the state or federal law:
 - Agents when used to promote fertility
 - Agents when used for cosmetic purposes or hair growth/removal
 - Drugs dispensed after their expiration date
 - Drugs which are experimental or investigational
 - Drugs used for erectile dysfunction
6. The following products, when provided for Medicaid members in skilled nursing facilities, are part of the per diem and therefore cannot be billed through a pharmacy claim.
 - OTC drugs, even if prescribed
 - Nursing stock drugs and durable medical equipment (e.g., saline, sodium chloride for inhalation and trach therapy)
 - Vitamin and mineral products
7. Drugs when used outside of FDA recommended or compendia supported indications or dosages per the [Social Security Act Section 1927](#).

Limited Coverage Categories

Non-Prescription / Over the Counter (OTC) Drugs:

- Aspirin, acetaminophen, NSAIDs, antacids, histamine-2 antagonists, iron supplements, non-sedating antihistamines, MiraLAX (and the generics), artificial tears, emergency and maintenance contraception, keratolytics, lice treatments, sodium chloride tablets, opioid antagonists, and nicotine replacement products
- These products must have valid NDC numbers, be included in a CMS rebate agreement, and prescribed by an authorized prescriber.
- A [recent list of OTCs NDCs](http://www.hidesigns.com/ndmedicaid) that have been paid can be found at www.hidesigns.com/ndmedicaid.

Dietary Supplements:

- Renal failure multivitamins, fat soluble vitamin combinations commonly used for cystic fibrosis, prenatal vitamins, folic acid, iron supplements, vitamins D, E, and injectable vitamin B₁₂
- The following metabolic supplements are covered for certain conditions: glycine, riboflavin, hydroxocobalamin, thiamine, biotin, niacinamide, pyridoxine and sodium and potassium citrate-citric acid

Anorexia, weight loss, and weight gain:

- Agents covered for anorexia/weight gain are megestrol, dronabinol, Serostim
- Agents covered for weight loss are phentermine, bupropion, naltrexone, and topiramate.
- Agents covered for antipsychotic induced weight gain include Victoza and metformin.

Medicare Part D Full Benefit Dual Eligibles if Part D plan does not cover:

- Prescription agents for symptomatic relief of cough and colds
- Non-Prescription/OTC: aspirin, acetaminophen, sodium bicarbonate tablets, MiraLAX (and the generics), artificial tears, sodium chloride tablets, fluoride dental gel, iron supplements
- Dietary Supplements as listed above

Hospice:

- Coverage of drugs not covered by hospice requires prior authorization for clinical review of medical necessity
- Reimbursement for drugs related to the member's terminal illness (i.e., hospice formulary) is included in the per diem rate for hospice covered services and will not be reimbursed separately through the Medicaid Pharmacy Program

Compounds:

- A payable ingredient must be included in the compound
- All NDC's submitted must be valid and not discontinued.
- ND Medicaid must calculate the reimbursement amount total for all ingredients:
 - 448-ED values must be the quantity dispensed for each individual ingredient of the compound.
 - 442-E7 is the sum of quantities submitted for 448-ED, irrespective of final volume or weight.
- Submission Clarification Code 08 can be billed to exclude non-payable ingredients from payment methodology, or the ingredient can be removed if an ingredient submitted is not included in the First Data Bank file or does not have a price.

Covered Outpatient Drug (COD) Status

Per 42 CFR 441.25, federal financial participation (FFP) is not available for drugs that are subject to a notice of opportunity for hearing issued by the Food and Drug Administration (FDA) and published in the Federal Register on a proposed order of FDA to withdraw the drug's approval because it has determined that the drug is less than effective for all its labeled indications. FFP is also not available for drugs that are identical, related, or similar to such drugs, as defined in 21 CFR 310.6.

In addition to the prohibition on FFP for such drugs, these drugs are not eligible for manufacturer rebates under the MDRP and therefore are non-covered by ND Medicaid.

For purposes of the Medicaid Drug Rebate Program (MDRP), labelers report these drugs quarterly to Medicaid Drug Programs (MDP) system with a covered outpatient drug (COD) status of 05 (DESI-5) or 06 (DESI-6):

- COD status 05 = DESI 5 - LTE/IRS drug for all indications
- COD status 06 = DESI 6 - LTE/IRS drug withdrawn from market

See the following links for information –

- [FDA Website for Drug Efficacy Study Implementation - DESI](#)
- [Rhode Island's Website - List of DESI Drugs](#)
- [Quarterly Rebate File Format from CMS](#)

Manufacturer/Labeler Drug Rebate Agreement Program

[Medicaid Drug Rebate Program | Medicaid](#)

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) requires that pharmaceutical manufacturers have a rebate agreement in effect with CMS for their pharmaceuticals to be reimbursed by Medicaid programs.

Only pharmaceuticals with a labeler code (first 5 digits of an NDC in the 5-4-2 NDC format) included in a rebate agreement are covered by Medicaid. Some pharmaceutical manufacturers have more than one labeler code. Therefore, if a manufacturer wants all products to be reimbursable, all labeler codes must be included in their rebate agreement with CMS.

Manufacturer rebate payments to the state are based on prescription claims payment data identified by NDC number.

The actual NDC number on the package from which the product is dispensed must be utilized on all claims where an NDC is required (e.g. pharmacy claims for drugs and diabetic supplies, medical claims for drugs).

Failure to correctly reflect the actual NDC number dispensed may negatively impact revenues generated for the state. Therefore, it is imperative that pharmacists take care to correctly identify the specific NDC number of the pharmaceutical dispensed.

Inaccurate records may result in:

- The Medicaid agency billing the wrong manufacturer
- Disputes between the state and the manufacturer in the amount of rebate due
- An audit of the records of pharmacy providers which may result in false claims charges and reversals of payments

Manufacturers are invoiced for rebates on all covered outpatient drugs billed through fee-for-service or managed care outpatient claims, both pharmacy and medical benefit claims, whenever ND Medicaid is a payer on the claim, whether as a primary, secondary, tertiary payer, etc.

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Drug Utilization Review (DUR) Requirements

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) requires that all state Medicaid programs include a retrospective and prospective drug utilization review (DUR) program, including patient counseling, for all covered outpatient pharmaceuticals. The primary goal of drug utilization review is to enhance and improve the quality of pharmaceutical care and patient outcomes by encouraging optimal drug use. The DUR program must ensure that prescribed medications are appropriate, medically necessary, and are not likely to result in adverse medical outcomes. The Medicaid DUR program includes retrospective DUR, prospective DUR, and the DUR Board.

Patient Counseling Requirements

State law [NDCC 61-04-13-01](#) outlines counseling requirements that apply to all ND licensed pharmacies and is enforced by the North Dakota Board of Pharmacy. ND Medicaid does not have additional requirements.

- Requirement for counseling for new and refill prescriptions
- Requirement for pharmacist or auxiliary personal authorized to make offer
- Requirement of whether counseling is required in situation where patient's representative is not readily available to receive a counseling offer or the counseling itself
- Requirement for mail order pharmacies

Counseling must include, in the exercise of professional judgement for the pharmacist considers significant, the following:

- The name and description of the medication
- The dosage form, dosage, route of administration, and duration of drug therapy
- Special directions and precautions for preparation, administration, and use by the patient
- Common severe side or adverse effects or interactions and therapeutic considerations that may be encountered, including their avoidance, and the action required if they occur
- Techniques for self-monitoring drug therapy
- Proper Storage
- Prescription refill information
- Action to be taken in the event of a missed dose

Per consultation with the ND Board of Pharmacy, ND Medicaid does not have requirements for documentation for offers of counseling, refusals of counseling, or actual counseling. Since there is no requirement for said documentation, there is no retention requirement.

All of the above patient counseling requirements apply to any pharmacy dispensing medications to ND Medicaid members.

Prospective Drug Utilization Review (ProDUR)

In compliance with OBRA 90 DUR requirements, pharmacy providers must screen each prescription for certain therapeutic problems using the OBRA 90 defined standards at point of sale before each prescription is dispensed.

Pharmacies must use a prospective DUR software database which screens for the therapeutic problems listed in paragraph 1. a - g, below. The pharmacy provider's prospective DUR program must be based upon predetermined standards, consistent with subsection 1927 of the Social Security Act. OBRA requires:

1. A pharmacist using his/her professional judgment shall review the patient record and each prescription drug order presented for therapeutic appropriateness by identifying the following, when possible:
 - a. Overutilization or underutilization
 - b. Therapeutic duplication
 - c. Drug-disease contraindications, where diagnosis is provided by the prescriber
 - d. Drug-drug contraindications
 - e. Incorrect drug dosage or duration of drug treatment
 - f. Drug allergies
 - g. Clinical abuse/misuse
2. Upon recognizing any of the above, the pharmacist shall take appropriate steps to avoid or resolve the problem which shall, if necessary, include consultation with the prescriber.

ND Medicaid ProDUR Audits

ProDUR audits are performed on all drug claims submitted through the POS system in the response transaction. These are supplemental to, not in lieu of, those required by law to be performed by the pharmacy provider. The ProDUR information provided to pharmacists by North Dakota Medicaid ProDUR audits are based on information from the current claim, from claim history for the same and different pharmacies, and from the member's diagnostic history on medical claims. The medical, clinical, and pharmaceutical information used in POS ProDUR audits are supplied by First Databank.

The following audits are performed:

Type of Audit	NCPDP Code
Early Refill (Same drug, same pharmacy)	ER
Drug Drug Interactions	DD
Duplicate Therapy Same Drug (Same drug, same or different pharmacy)	ID
Therapeutic Duplication	TD
Medical Disease Diagnosed Contraindicated	MC
Drug Disease Contraindicated	DC
Adult High Dose	HD
Geriatric High Dose	HD
Pediatric High Dose	HD
Adult Low Dose	LD
Geriatric Low Dose	LD
Pediatric Low Dose	LD
Additive Toxicity	AT
Iatrogenic Side Effect (Inferred)	IC

DUR Override Codes

Pharmacists billing via POS are required to evaluate any ProDUR Information that is returned with a claim and intervene appropriately. One conflict code, one intervention outcome code, and one outcome code are needed to override an alert.

Conflict Codes

NCPDP Code	NCPDP Code Description
DC	Drug-Disease (Inferred) precaution
ER	Early refill
LR	Underutilization (Late Refill)
MC	Drug-Disease (Reported) precaution

Intervention Codes

NCPDP Code	NCPDP Code Description
M0	Prescriber consulted
P0	Patient consulted
R0	Pharmacist consulted other source

Outcome Codes

NCPDP Code	NCPDP Code Description
1B	Filled Rx as is
1C	Filled with different dose
1D	Filled with different directions
1F	Filled with different quantity
1G	Filled with prescriber approval

Prior Authorization

The prior authorization (PA) program requires certain criteria be met before payment of claims is authorized. Criteria may consist of clinical parameters or trial and failure of first or second-line therapies as noted in the [Preferred Drug List](#). ND Medicaid uses automatic PA based on diagnosis or electronic claims review and manual PA which requires the submission of a form and/or chart notes to be reviewed by a pharmacist or technician. Acentra Health serves as ND Medicaid's prior authorization vendor and reviews manual prior authorization requests. ND Medicaid may also review cases on an individual basis for exceptions.

Retrospective DUR

The retrospective DUR program involves reviews of patient drug history profiles generated from Medicaid paid claims data. The reviews are based upon predetermined standards consistent with subsection 1927 of the Social Security Act.

The retrospective review of the patient drug history profiles includes evaluation for:

1. Therapeutic appropriateness
2. Overutilization and underutilization
3. Appropriate use of generic products
4. Therapeutic duplication
5. Drug-disease contraindications
6. Drug-drug interactions
7. Incorrect dosage or duration of therapy
8. Clinical abuse/misuse

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Reimbursement of Drugs

Federal Upper Limits (FULs)

In compliance with 42 Code of Federal Regulations (C.F.R.) 447.512 and 447.514, reimbursement for drugs subject to Federal Upper Limits (FULs) may not exceed FULs in the aggregate.

Professional Dispensing Fee

In all instances, the professional dispensing fee will be \$12.46 (does not apply to Physician Administered Drugs):

- For claims with days supply 28+ days: one dispensing fee is paid every claim
- For claims with days supply < 28 days: one dispensing fee will be paid per 28 days
 - May override with NCPDP D.0 Submission Clarification Code of 5 as appropriate (unit of use products, liquids, creams, antibiotics, etc.)

Payment Methodology

1. For prescribed drugs that are covered by North Dakota Medicaid, including covered OTC drugs, North Dakota Medicaid will reimburse at the following lesser of methodology effective 10/1/2016 (Lesser of a, b, or c).

- a. The usual and customary charge to the public*
- b. North Dakota Medicaid's established Maximum Allowable Cost (MAC)** for that drug plus the professional dispensing fee
- c. Current National Average Drug Acquisition Cost (NADAC)** for that drug plus the professional dispensing fee

OR

If there is no NADAC for a drug, the current wholesale acquisition cost (WAC) of that drug plus the professional dispensing fee.

* Federal Supply Schedule purchased drugs: Providers are required to use their acquisition cost plus the professional dispensing fee as their usual & customary (Refer to 1a of this section).

** MAC and NADAC are based on provider supplied acquisition cost surveys. For reimbursement lower than cost, dispute forms are available to submit for each:

[NADAC and SMAC Dispute Forms](#)

2. 340B drugs (includes traditional 340B and any 340B drugs where the upfront cost does not include the 340B discount but is later provided as a rebate to the provider) are reimbursed with the following lesser of methodology (less of a or b):
 - a. The 340B MAC pricing (ceiling price) plus the professional dispensing fee, OR
 - b. Actual acquisition cost plus the professional dispensing fee. Actual acquisition cost means 340B ceiling price for any 340B drugs where the upfront cost does not include the 340B discount but is later provided as a rebate to the provider.

For more information regarding 340B, including how to indicate drug is 340B:

- See 340B Program in this manual
 - See [payer sheet](#)
3. Indian Health Service, Tribal and urban Indian pharmacies are paid the encounter rate by ND Medicaid regardless of their method of purchasing (one pharmacy encounter payment per person per facility per date of service). As these claims are paid through an encounter rate, they are not included in the invoicing process for the Medicaid Drug Rebate Program.

The reimbursement methodologies above also apply to:

1. Drugs not distributed by retail community pharmacies (e.g., long-term care facilities and specialty mail order drugs)
2. Clotting factors from specialty pharmacies, Hemophilia Treatment Centers (HTC), and Centers of Excellence
3. Drugs acquired at Nominal Price (outside of 340B or FSS)
4. Physician Administered Drugs (no professional dispensing fee will be paid for Physician Administered Drugs)

Brand Name Drugs – Generic Equivalent Exists

ND Medicaid Requires Brand Name:

ND Medicaid may require brand name when the brand is less expensive net of rebates than available generics. Pharmacies must bill with a DAW 9 for the claim to be reimbursed at brand pricing rather than the lower generic pricing.

Other Insurance Requires Brand Name:

Pharmacies should attempt to bill DAW 9. If the claim is rejected with 22 – INV DAW/PROD SELECTION CD, pharmacies must call ND Medicaid for further instructions.

Generic not available:

Temporary market shortages, or isolated geographic shortages may cause a pharmacy to bill for a brand because they do not have access to a generic. In this case, pharmacies should attempt to bill DAW 8 and verify adequate payment. If payment is not adequate, pharmacies must call ND Medicaid for further instructions. ND Medicaid

will not allow DAW 1 or 9 to be used due to a temporary market shortage or isolated geographic shortage.

Copays

There is no copay for any service for North Dakota Medicaid

Recipient Liability

Recipient liability is also known as “excess income” or “spend down.”

Recipient liability is the monthly amount a member must pay toward the cost of medical and/or pharmacy services before they become eligible for Medicaid benefits. Recipient Liability is applied to the first claims* billed each month (whether medical or pharmacy). It cannot be waived.

Recipient liability is not drug specific and is not a copay. Recipient Liability is most comparable to a deductible.

For POS claims, at the time a prescription is billed to the state via the Point-of-Sale (POS) System, any recipient liability remaining is applied immediately to that claim and is due and payable at that time. Recipient liability is immediately updated by each claim (whether medical or pharmacy). The weekly remittance advice will reflect that transaction.

If a member does not pick up an ordered prescription that has recipient liability by the end of the next business day, you must reverse the claim to ensure that the recipient liability is applied to other services received by the member. If the member comes to pick up the prescription later, simply rebill and any remaining recipient liability will be applied.

*For persons residing in long term care facilities, recipient liability is not applied to pharmacy claims. The member’s recipient liability is applied against the facility charge, which is received at the end of in the month. In rare cases, the facility charge will be insufficient to satisfy recipient liability. When this happens, the state will recoup payments from the pharmacy which will then have to bill the member or family for any previously paid claims. Payment recoupment will be by claim adjustment by state staff and will be reflected on a remittance advice.

Third party Liability

For questions regarding Third Party Liability (e.g., private insurance, Medicare), please call our TPL help desk at 701-328-2347 or e-mail at medicaidtpl@nd.gov.

Other insurance or other responsible party (third party liability, including court ordered insurance) may be identified through the member, the human service zone, the member eligibility verification system (VERIFY), or the Point-of-Sale (POS) system. By law, all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

Claims Processing Rules

A claim will deny for the following instances:

1. If there is no insurance payment indicated on the claim and there is TPL indicated on the state MMIS system.
2. The number of other payers on the claim must match the number of other payers in the MMIS system.
3. The other payer amount paid (431-DV) field is a negative value.

A claim will continue processing for the following instances:

1. If there is an insurance payment indicated on the claim and there is no TPL in the state MMIS system. State staff will review these claims, contact the member, and enter the insurance into the system.
2. If there is worker's comp or an accident policy in the state system. State staff will review these claims, contact the pharmacy, and ask them to rebill as appropriate.

Formulary and Service Authorization Rules

ND Medicaid cannot be billed as the primary payor in the following cases:

- Primary insurance denies service authorization due to medical necessity
- Primary insurance processes non-formulary medication but not does pay because a formulary medication option exists

If the primary insurance denies a prescription, all options with the primary insurance must be exhausted (appeal for formulary coverage, prior authorization, changing medications to a formulary medication, etc.). Medications that are fully excluded where no alternative exists for coverage by primary insurance may be reviewed for coverage by providing proof of exclusion and inability to obtain prior authorization.

Medicare Coverage

ND Medicaid does not provide outpatient prescription medication coverage (e.g., retail pharmacy) for individuals who are eligible for Medicare, even when the member is not enrolled in a Medicare Part D plan. Members cannot simply choose to have medication coverage through Medicaid by choosing to not enroll in or disenrolling from a Medicare Part D plan.

If a member is eligible for Medicare, but not currently enrolled in a Medicare Part D plan, Humana LiNET may be billed for drug coverage until the member can enroll into a Medicare Part D plan. ND Medicaid does not administer this program. Please direct inquiries to Humana LiNET.

Medicare Advantage plan claims do not automatically cross over for Part A and Part B services. The remaining patient responsibility amount must be billed to Medicaid through a medical 837p transaction, even if the Medicare Advantage plan requires billing through an NCPDP transaction.

Website: [Medicare's LINET Pharmacy Resources - Humana](#)

Phone: 1-800-783-1307

340B Program

Covered Entities

Covered entities must indicate they wish to be 340B providers in their provider enrollment paperwork. Only those providers who have enrolled as 340B providers will be allowed to bill for 340B products.

Contract Pharmacies

Contract pharmacies are not allowed to bill for 340B product and must carve out ND Medicaid unless the contract pharmacy is only considered a contract pharmacy due to the ND pharmacy ownership law and an agreement has been reached between the provider and ND Medicaid.

Fee-for-Service

For pharmacy and physician administered drug claims for traditional Medicaid and pharmacy drug claims for Medicaid expansion, 340B product billing is allowed for those enrolled with ND Medicaid and identified in their enrollment as 340B providers.

However, ND Medicaid pays a calculated ceiling price, and most providers choose to not use 340B supply.

Managed Care

For physician administered drug claims for Medicaid expansion, 340B product billing is not allowed.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are paid an encounter rate so their claims are not eligible for rebates. FQHCs may use 340b supply if they wish.

Billing Instructions:

These require apply whenever ND Medicaid is a payer on the claim, whether as a primary, secondary, tertiary payer, etc.

Payer Sheet

Please see our [payer sheet](#) for BIN, PCN, Group numbers.

Pharmacy Dispensed Drugs

Covered entities as described in section 1927 (a)(5)(B) of the Social Security Act are required to bill no more than their actual acquisition cost plus the professional dispensing fee with a clarification code of 20 (when using traditional 340B and any 340B drugs where the upfront cost does not include the 340B discount but is later provided as a rebate to the provider for traditional or expansion Medicaid prescriptions). Actual acquisition cost means 340B ceiling price for any 340B drugs where the upfront cost does not include the 340B discount but is later provided as a rebate to the provider.

ND Medicaid, AIDS Drug Assistance Program (ADAP), and Children Health Insurance Program (CHIP) will exclude all 340B claims (includes traditional 340B and for any 340B drugs where the upfront cost does not include the 340B discount but is later provided as a rebate to the provider) billed with a clarification code of 20 from the Medicaid drug rebate invoicing process to avoid duplicate discounts.

Physician Administered Drugs

Covered entities as described in section 1927 (a)(5)(B) of the Social Security Act are required to bill no more than their actual acquisition cost and utilize the 340B specific modifiers (TB or UD) on the claim line for the drug when billing 340B product to traditional ND Medicaid (includes traditional 340B and any 340B drugs where the upfront cost does not include the 340B discount but is later provided as a rebate to the provider). Actual acquisition cost means 340B ceiling price for any 340B drugs where the upfront cost does not include the 340B discount but is later provided as a rebate to the provider.

ND Medicaid, AIDS Drug Assistance Program (ADAP), and Children Health Insurance Program (CHIP) will exclude all 340B claims (includes traditional 340B and any 340B drugs where the upfront cost does not include the 340B discount but is later provided as a rebate to the provider) billed on a claim line with a TB or UD modifier from the Medicaid drug rebate invoicing process to avoid duplicate discounts.

Excluded Products:

Some products are required to be excluded from 340B billing. [Excluded NDCs for 340B](#)

Out of State Pharmacies

All information in this 340B section also applies to out-of-state pharmacies

HRSA Medicaid Exclusion File

Since our 340B claims are identified using modifiers during claim submission, we do not use the HRSA Medicaid Exclusion File.

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Adjustments to Payments

Reversals

Pharmacists may retract any claim that has been paid by submitting an NCPDP reversal transaction. Reversals may be used in many circumstances. Following are some examples:

- a. A prescription is not picked up by the member. Pharmacies are expected to reverse claims not picked up within 15 days to ensure accurate dispense dates and drug utilization review edits.
 - i. Pharmacies must reverse a claim that has recipient liability by the end of the next business day to ensure that the recipient liability is applied to other services received by the member.
- b. Prospective Drug Utilization Review (ProDUR) information provided by the system as a claim was paid results in a prescription not being dispensed or being modified. If modified, the new claim may be submitted at any time after the reversal.
- c. An error was made when submitting the claim. A corrected claim may be submitted and processed at any time after the reversal. If you feel an error has been made in payment as shown on your remittance advice, you may correct the error by reversing and re-billing with the necessary corrections
- d. A claim with inaccurate information was submitted resulting in a paid claim. The claim can be reversed and resubmitted with corrected information.

Refunds

If you discover that you have been overpaid, please contact the appropriate benefit team:

Medicaid Expansion or Traditional Medicaid Programs:

Phone: 701-328-4086

Fax: 701-328-1544

Email: medicaidpharmacy@nd.gov.

Special Health Services (SHS) Program

Phone: 1-701-328-2436

Fax: 701-328-1645

dohcshsadm@nd.gov

AIDS Drugs Assistance Program (ADAP)

Phone: 1-701-328-2379

Fax: 1-701-328-0338

gmathern@nd.gov

Denied POS Claim

If a claim has been denied for any reason and you think it is payable, you may rebill via POS, making any needed claim corrections. Examples include:

- a. A claim is denied because the Medicaid ID number is invalid. Correct the number and resubmit.
- b. A claim is denied because the member is not eligible. If the member later establishes eligibility for the dispensing date, resubmit the claim via POS within the one-year filing limit.

Long Term Care Credit

Pursuant to State Medicaid Director Letter #06-005, any drug products that are unused due to a discontinued prescription or to the discharge or death of the member must be restocked by the dispensing pharmacy and credited to the Medicaid program (returns must comply with the North Dakota State Board of Pharmacy rules).

The credit may be made by reversing the original transaction and then re-submitting with the adjusted actual units utilized.

Automatic Refill and Fill Sync Programs

Medicaid does not pay for any prescription (original or refill) based on a provider's auto-refill policy. Members or providers cannot waive the explicit refill request and enroll in an electronic automatic refill program.

Medicaid does not pay for any prescription without an explicit request from a member or the member's responsible party, such as a caregiver, for each refilling event. The pharmacy provider shall not contact the member to initiate a refill unless it is part of a good faith clinical effort to assess the member's medication regimen. A prescription with remaining refills authorized does not in itself constitute a request for the provider to refill the prescription.

Medication Bubble Packaging

Medicaid does allow bubble packaging for compliance. Medicaid does not cover additional supply based on discontinued or modified prescriptions included in bubble packaging programs. The bubble packaging must be repackaged to utilize medications that have already been paid and are to be continued.

Medicaid does allow bubble packaging for use in living arrangement where medications are administered by direct care personnel. Any medication that is already paid for by ND Medicaid must be utilized and repackaged for administration by direct care personnel. Medicaid does not pay for additional medication based on a facility's admission and bubble packaging policies.

Laws governing freedom of choice of pharmacy and long-term care credits must be followed.

Supplemental Compound Payment

The supplemental compound payment is not intended to provide additional payment for ingredients that were reimbursed through the compound claim or for ingredients that are not payable (e.g., obsolete NDC). Bulk compounds and Expansion claims are not eligible for the supplemental payment.

Medicaid may allow a supplemental compound payment for an individual compound if:

- Ingredient waste is not wholly reimbursed through the compound claim. The smallest available package size should be used to minimize waste.
- Hazardous compound precautions are required.
- Higher level of compound complexity is required with no available alternatives.
- Compound ingredients require prior authorization (not reimbursed through the compound claim), and there are no suitable alternatives:
 - Unable to use alternatives due to allergy or clinical contraindication
 - Shorter beyond-use-date (BUD) or storage conditions leading to substantial extra compounding/dispensing

Supplemental compound payment may be requested through prior authorization ([SFN 511](#) form) for HCPCS code S9430.

- Submit the SFN 511 form once for each individual compound (specific to the member and the compound)
- S9430 must be billed on a medical claim:
 - 1 unit may be billed per dispensing.
 - The authorization number must be included on the claim.
- Claim status for the supplemental payment can be viewed in the online portal, and payment can be viewed on the pharmacy's remittance advice.

Coordinated Services Program (CSP)

When a member is placed on the Coordinated Services Program (CSP), that member is limited to services provided by the CSP providers (pharmacy, dentist, and primary CSP prescriber), or a provider with a referral in place by their primary CSP prescriber and the referral is on file with Medicaid. Providers are made aware they are a CSP provider by a mailed notice.

Claims prescribed by or billed by non-CSP providers will be rejected with a detailed message. Therefore, the only claims payable for a CSP member are those prescribed by the primary CSP prescriber and billed by the primary CSP pharmacy, or providers

with referrals on file with ND Medicaid. An exception can be requested by contacting medicaidcsp@nd.gov or 701-328-2346.

Placing a Referral

If the prescription is not from the primary CSP prescriber or a referred prescriber, the primary CSP prescriber must send the referral information to medicaidcsp@nd.gov. The pharmacy can inform the member and the prescriber that the primary CSP prescriber must send a copy of the CSP referral information to the state office. When a referral is verified, the pharmacy will be able to bill for prescriptions written by the referred prescriber. It is inappropriate to simply change the prescriber to the primary CSP prescriber if there is no referral.

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Fraudulent Claim Submission

ND Medicaid utilizes a Program Integrity Unit to carry out the surveillance and review process to protect the integrity of the Medicaid program, which is federally mandated.

For detailed information and procedures of the program:

[Compliance, Reporting, Fraud & Abuse](#) and the [Coordinated Services Program Manual](#)

For information how to report suspected Medicaid fraud:

[Medical Services Fraud and Abuse](#)

Fraud, Waste, and Abuse Inquiries

Phone: 1-800-755-2604

Email: medicaidfraud@nd.gov

Form: [Suspected Fraud Referral](#) form

Identifying Fraud, Waste, and Abuse

Fraud, waste, and abuse (FWA) by members, pharmacies, and prescribers is identified in a variety of ways. If fraud, waste or abuse is identified or suspected, claims may be rejected, or prior authorization may be required. Referrals may also be made to the Program Integrity Unit or Surveillance Utilization Review Unit for audit.

Controlled substance FWA by members, pharmacies, and prescribers is identified using prescription drug monitoring program (PDMP) reports and reports of claims. Providers are required to check the prescription drug monitoring program before prescribing or dispensing controlled substances to a Medicaid member. ND Medicaid defines “before prescribing or dispensing” as one or more of the following:

- New or unestablished treatment
- Every six months during established treatment
- For early refills or patterns of taking more than prescribed dosage
- Upon suspicion or known drug overuse, diversion or abuse

The Program Integrity Unit reviews claims when they receive reports of suspected FWA from isolated cases or patterns and findings of FWA from other entities. Reports of claims are also reviewed on a regular basis to detect patterns of FWA of services from members, pharmacies, and prescribers such as providing services past date of death or that are outside of their scope of practice.

If member FWA is identified, the Program Integrity Unit may refer the member to the Coordinated Services Program.

If provider or prescriber FWA is identified, the Program Integrity Unit may recoup payment, provide provider education, or make referrals to the Medicaid Fraud Control Unit for investigation.

Claims submitted in error or with false information must be reversed or may be recouped on audit.

The following are examples of activity that may be considered fraudulent:

Modified Prescriptions

Claims must be submitted to ND Medicaid as true and accurate based on the prescription issued by a valid prescriber. The claim information cannot be modified from the prescription to produce a paid claim, including days of supply and diagnosis unless the prescription is modified in accordance with rules governed by the North Dakota State Board of Pharmacy.

Non-Member Utilization of Services

A prescription filled for a Medicaid member must be for use for the indicated eligible member. The dispensed medication may not be transferred for use by a non-ND Medicaid eligible individual, including family members or friends without payer coverage.

Services Not Requested

A paid claim must be the result of a valid prescription requested to be filled by and subsequently picked up by a member. Per § 456.705 Prospective Drug Review (c) and 1927 (g)(2)(A)(ii), signature or other documentation of counseling is not required by ND Medicaid as counseling is simply part of the scope of practice for pharmacists under state law (NDCC 61-04-13-01). ND Medicaid does have requirements for paid claims that are not picked up from the pharmacy in a timely fashion. Please refer to “Reversals” section (page 26) of this manual for more information.

Any prescriptions filled without a request from a member, or their responsible party may be subject to recovery. Any pharmacy provider who pursues a policy that includes filling prescriptions on a regular date or any type of cyclical procedure may be subject to audit, claim recovery or possible suspension or termination of their provider agreement.

Services for Deceased Individuals

The date of service for a claim cannot be after the date of death. The claim may process and pay if the date of death has not yet been updated in the state eligibility system. Paid claims with a date of service after the date of death will be recouped on audit. For situations with nursing home or other similar end of month billing, the pharmacy may resubmit the end of month claims with the date of death as the date of service once they receive the accurate date of death information.

Third Party Liability

If a pharmacy submits a claim (with false information populated in 431-DV or 352-NQ) that was denied by the primary insurance to Medicaid for payment, that will be considered fraud. Field 352-NQ cannot be populated unless the primary insurance actually processed the claim as a paid claim.

Federal anti-kickback Statute

Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b))

Claims partially or fully paid with manufacturer coupons or direct-to-consumer sales may not be billed to the Medicaid program for additional payment and may not be used on a person eligible for Medicaid with the expectation that the Medicaid program might be billed for the drug in the future.

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Eligibility and Claim Inquiry

The Automated Voice Response System (AVRS) and the MMIS portal will return eligibility results for traditional Medicaid and Medicaid Expansion members. Eligibility can also be verified by calling ND DHHS Eligibility at 1-844-854-4825 (for traditional and expansion) or Blue Cross Blue Shield (for expansion) at 1-833-777-5779

Automated Voice Response System (AVRS)

Enrolled providers may readily access detailed information on a variety of topics using a touch-tone telephone. AVRS options available include:

- Member Inquiry
- Payment Inquiry
- Service Authorization Inquiry
- Claims Status

AVRS Access Telephone Numbers (available 24/7)

Phone: 1-877-328-7098

Phone: 1-701-328-7098

For detailed instructions on how to use AVRS, please reference [Provider Requirements](#) located at [Provider Guidelines, Manuals and Policies](#). AVRS does not contain information for all programs administered by the Department of Health and Human Services.

Please reference the following for more information:

Traditional Medicaid

Eligibility information can be obtained by using AVRS.

Special Health Services (SHS):

SHS eligibility information is not available on AVRS. Eligibility for SHS members must be determined by contacting the state SHS office.

Breast and Cervical Cancer Detection (Women's Way)

Eligibility information can be obtained by using AVRS. The Centers for Disease Control and Prevention funds this breast and cervical cancer early detection program, known as Women's Way.

Children's Health Insurance Program (CHIP)

Eligibility information can be obtained by using AVRS.

Medicaid Expansion

Eligibility information can be obtained by using AVRS. Medicaid Expansion pharmacy benefits are administered by North Dakota Medical Services. Please visit

the [ND DHHS Medicaid Expansion Website](#) for information on medical benefit claim processing.

MMIS Web Portal Eligibility Verification

Step 1: Navigate to eligibility information through the [MMIS web portal](#) (only enrolled providers can access MMIS web portal).



Step 2: Fill out member information details (2 of these 3 fields must be filled out to produce results).

Member Information			
Member ID	Date of Birth	Last Name	First Name
1 <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Step 3: Fill in the Service From Date and Service To Date. Both are required.

Step 4. Fill in the Service Type to equal 30-Health Benefit.

Service From Date	Service To Date	Service Type	Action
<input type="text"/>	<input type="text"/>	30-Health Benefit	<input type="button" value="+"/> <input type="button" value="X"/>

Step 5: View the plans that the member is enrolled in under the Benefit plan section. Please note that the Plan From and Plan To will reflect the dates that were used in the Service From Date and Service To Date fields under the Eligibility Inquiry section, not the actual eligibility span.

Benefit Plan		
Plan Description	Plan From	Plan To
Developmentally Disabled Waiver	10/01/2022	10/25/2022
Health Tracks/Early Perdic Scrn Det Trmt	10/01/2022	10/25/2022
Medicaid Fee For Service	10/01/2022	10/25/2022

1 - 3 of 3

Step 6: View the confirmation of active eligibility under the Eligibility Confirmation section. The Eligibility Status must equal Yes.

Eligibility Confirmation	
* Required Field	
Service From Date: 10/01/2022 Eligibility As of date: 10/01/2022	Service To Date: 10/25/2022 Eligibility Status: Yes

Step 7: View other fields of interest including TPL Spans, Lock-In Status, and Other General Information (which includes recipient liability information)

TPL Spans	
Carrier ID	Carrier Name
0 - 0 of 0	
Lock-in Spans	
Begin Date	End Date
0 - 0 of 0	
Other General Information	
Is There Any Recipient Liability Involved? No	

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Medicare Part B Covered Items

Certain items of durable medical equipment, supplies and drugs are payable by Medicare on behalf of members who are eligible for both Medicare and Medicaid. These items include:

- Ostomy & Urologic Supplies
- Wheelchairs
- Crutches
- Canes
- Oxygen Equipment
- Braces (Orthopedic)
- Lumbosacral Supports
- Corsets (Orthopedic)
- Prostheses
- Medically necessary Durable Medical Equipment from a licensed prescriber for use in the home (Purchase & Rental)
- Diabetic supplies, including blood glucose pumps, monitor, strips, and lancets
- Medicare Part B covered drugs

How to Bill Medicare Covered Items

1. Bill Medicare on CMS 1500 forms or electronically
[Electronic Health Care Claims | CMS](#)
2. When the claim has been processed by Medicare, it should automatically cross over to Medicaid for consideration of payment of any deductible and coinsurance amounts that are due. Medicare Advantage plan claims do not automatically cross over for Part A and Part B services. The remaining patient responsibility amount must be billed to Medicaid through a medical 837p transaction, even if the Medicare Advantage plan requires billing through an NCPDP transaction.
3. Medicaid will then reimburse for any deductible amount due from the member plus any coinsurance amount due, if any, up to the Medicaid allowable payment, for each item.
4. If you have not received payment within 60 days of billing Medicare, bill electronically or through the web portal. Be sure to include the Medicare payment on the submission. [Instructions for billing electronically or through the web portal](#) are available under Billing/Claims.

[MMIS - ND Health Enterprise Medicaid Management Information System | Health and Human Services North Dakota](#)

Durable Medical Equipment (DME)

For those pharmacies dispensing Durable Medical Equipment (DME), you are required to comply with everything in the DHHS [DME Manual](#).

Covered diabetic supplies (strips, lancets, machines, syringes, pen needles, tubeless insulin pumps, smart insulin pen, continuous glucose monitors) and inhaler spacers are reimbursable using NDC numbers billed as a POS claims, provided the primary insurance also allows POS billing. Medicare Part B claims are not payable through POS.

Non-Emergent Medical Transportation

- ND Medicaid covers transportation to covered medical services, including pharmacies. The member should contact their human service zone or tribal office to coordinate transportation. Please keep this in mind if you hear of non-adherence to office visits or medication due to transportation issues.
- [Non-Emergent Medicaid Transportation program](#)

Routine Drugs, Supplies & DME for Long Term Care Facilities

Some items are reflected on facilities cost statement as part of their per diem rate and in not payable to pharmacy or other suppliers. Please see the following policies for more information:

[Health Facilities](#)

Pharmacy POS items that are allowed for separate payment

1. Insulin Vials, Pens and Syringes
2. IV and SQ Medications
3. IV Solutions (if medication admixed)
4. Prescription Drugs, except Vaccines as covered under this manual

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Vaccines

For detailed information on vaccine coverage and billing, please reference the [Immunizations](#) policy located at [Provider Guidelines, Manuals and Policies](#).

Medical Billing

Traditional Medicaid Billing Inquiries

Please contact the medical call center rather than the pharmacy call center:

Phone: 701-328-7098

Email: mmisinfo@nd.gov.

Medicaid Expansion Billing Inquiries

Please contact Blue Cross Blue Shield if the recipient is enrolled with Medicaid Expansion. For more information, please contact Blue Cross Blue Shield.

Phone: 1-833-777-5779

[State Medicaid Expansion Website](#)

[Blue Cross Blue Shield Website](#)

Provider Requirements

- The pharmacist provider must:
 - Have an active ND state pharmacist license
 - [Enroll as a ND Medicaid provider](#) (requirement effective July 1, 2023)
 - Affiliate with each practice location
- All NPIs billed on a claim must be enrolled with ND Medicaid

Site Requirements

The business where services are provided (site of service) must:

- Be located within the state of ND or the local trade area within 50 miles of the ND border (The [Out of State Services](#) policy outlines the requirements for out-of-state services)
- Have appropriate size and accommodations for services provided
- Be enclosed sufficiently to prevent:
 - Encounter from being heard and/or seen by others
 - Interference by distracting noise from other areas of the business
- Refer to [Telehealth Policy](#) if provided via synchronous telehealth or audio-only telephone

Documentation Requirements

Quality documentation used must:

- Allow manual entry of members
- Be designed to optimize therapeutic outcomes
- Be able to track and report interventions and outcomes (within 5 business days when requested by Department)
- Maintain records in accordance with HIPAA requirements and other state and federal regulations
- Maintain records as outlined in [Provider Requirements](#).

Billing and Payment

Providers will bill for services electronically using EDI 837 transactions with appropriate ICD-10-CM codes. Billing systems must comply with HIPAA privacy and security requirements and regulations. All claims billed must be medically necessary as defined in [Provider Requirements](#).

If a provider does not meet requirements at the time the service is provided, the service will not be considered for payment. Incentives and discounts cannot be provided to ND Medicaid members, and pharmacists providing medical services cannot charge copays to ND Medicaid members.

ND Medicaid enrollment is required for all NPIs billed on a claim

- Billing NPI: NPI to receive payment
- Ordering NPI: NPI that placed the order
- Rendering NPI: NPI performing the service

Required elements:

- CPT Code
- IDC-10-CM code
- Modifier / Place of Service

Refer to the [Provider Guidelines, Manuals, and Policies](#) for more information:

- [Instructions for billing electronically or through the web portal](#)
- [Timely Filing](#)
- [Physician Administered Drugs](#)

Remittance Advice

- [Electronic Remittance Advice Enrollment](#)
- [Remittance Advice](#)

Payment

- [Professional Fee Service Schedule](#)

Please see additional information on pharmacist as provider billed services:

- [Anticoagulation Management for Warfarin](#)
- [Continuous Glucose Monitoring \(CGM\)](#)
- [Tobacco Cessation](#)
- [Drug Administration and Immunizations](#)
- [Medication Therapy Management \(MTM\)](#)

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Anticoagulation Management for Warfarin

CPT Codes:

93793: Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab INR test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed.

Documentation Requirements:

Medical record must support billing the anticoagulation management CPT code, document what was discussed during the encounter, and show a significant and separately identifiable service. Items to document include the following elements:

- Member's name and date of birth
- Clinical encounter date of service (DOS)
- Pharmacist's name and credentials
- Patient's primary and/or treating HCP
- Indication for anticoagulation
- Current INR and goal INR range
- Other relevant laboratory values
- Risk factors and signs/symptoms of bleeding and thromboembolic events
- Assessment of factors affecting INR
 - Adherence
 - Diet
 - Physical activity
 - Alcohol and tobacco use
 - Other medications
- Current warfarin dose and adjustment (if applicable)
- Instructions, education, and resources provided
- Other tests and/or referrals (as needed)
- Date of next INR and follow-up

Continuous Glucose Monitoring (CGM)

CPT Codes

95249: Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording

94250: (only reimbursed by ND Medicaid when required by another payer): Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording

95251: Ambulatory continuous glucose monitoring of interstitial fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

Documentation Requirements: CGM

Medical record must support billing the CGM CPT codes, document what was discussed during the encounter, and show a significant and separately identifiable service. Items to document include the following elements:

- Member's name and date of birth
- Clinical encounter DOS
- Pharmacist's name and credentials
- Patient's primary and/or treating HCP
- CGM data download (must include minimum of 72 hours of data), analysis, interpretation, and report(s)
- Other relevant laboratory values (e.g., HbA1c)
- Assessment of factors affecting blood glucose levels
 - Adherence
 - Alcohol use
 - Illness
 - Diet
 - Physical activity
 - Other medications and conditions
- Current treatment plan and adjustment (if applicable)
- Instructions, education, and resources provided
- Other tests and/or referrals (as needed)
- Date of follow-up

Tobacco Cessation

CPT Codes

99406: Smoking and tobacco use cessation counseling visit is greater than three minutes, but not more than 10 minutes

99407: Smoking and tobacco use cessation counseling visit is greater than 10 minutes

Documentation Requirements

Medical record must support billing the tobacco cessation CPT codes, document what was discussed during the encounter, and show a significant and separately identifiable service. Items to document include the following elements:

- Member's name and date of birth
- Clinical encounter DOS
- Pharmacist's name and credentials
- Member's primary and/or treating health care provider (HCP)
- Tobacco use
- Assessment of willingness to attempt to quit
- Counseling, education, and resources provided
 - Advice to quit
 - Impact of smoking provided to patient
 - Methods and skills recommended to support cessation
- Medication management
- Quit date
- Referrals (as needed)
- Date of follow-up
- Amount of time spent counseling

An entry in the health record stating that the provider spent 11 minutes counseling about tobacco use will not meet the standard for medical necessity for billing tobacco cessation CPT codes

Drug Administration and Immunizations

Vaccines are not covered through the pharmacy point-of-sale (POS) system and must be billed on a medical claim. [Immunizations \(Vaccines/Toxoids\) Policy](#) and can be accessed online for more information on billing vaccines and vaccine administration.

CPT Codes

96372: Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

90471: Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections; 1 vaccine (single or combination vaccine/toxoid)

90472: Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)

90473: Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)

90474: Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)

G codes: Vaccine counseling information is included in Immunizations (Vaccines/Toxoids) Policy

ICD-10-CM Codes

Z23: Encounter for immunization

Documentation Requirements

Medical record must support billing the drug and/or vaccine CPT codes. Items to document include the following elements:

- Member's name
- Member's date of birth
- Clinical encounter DOS
- Pharmacist's name and credentials
- Primary HCP and contact information
- Ordering and/or protocol HCP and contact information
- Time spent counseling
- Administration information (if applicable)
 - Product name
 - Route and site of administration
 - Dose administered
 - Adverse effects/reactions
 - Vaccine manufacturer

- Vaccine lot number
- Vaccine Information Statement (VIS) edition date
- Date the VIS was provided

Medication Therapy Management (MTM)

CPT Codes

Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided

99605: Initial 15 minutes, new patient

99606: Initial 15 minutes, established patient

99607: Each additional 15 minutes (list separately in addition to code for primary service)

ICD-10-CM Codes

Z71.89: Other specified counseling

Member Eligibility

Member not eligible for MTM services if:

- Eligible for Medicare
- Resides in setting where medications are managed/administered by facility staff (e.g., inpatient, incarcerated, skilled nursing facility, etc.)
- [Medicaid Expansion member](#) (medical claims are covered by the managed care organization, not the state Medicaid program)

Member Identification

The objectives of the MTM program are to coordinate health care, improve the health of Medicaid-eligible individuals, and manage health care expenditures.

- Members may be identified for MTM services by ND Medicaid or referred by filling pharmacies, HCPs, or MTM providers
- MTM-eligible members will not be electronically fed into any one MTM software platform, so manual entry of member may be required

In addition to the above objectives, general guidelines to evaluate medical necessity for MTM are outlined in [MTM Patient Identification Worksheet](#).

Documentation Requirements

Medical record must support billing the MTM CPT codes, document what was discussed during the encounter, and show a significant and separately identifiable service. An entry in the health record stating that the provider spent 11 minutes counseling about medication use will not meet the standard for medical necessity for billing MTM CPT codes. General guidance for conducting the MTM encounter is outlined in [MTM Encounter Guidance](#).

Items to document include the following elements:

- Demographics and History:
 - Member's name

- Date of birth
 - Member's contact information
 - Gender
 - List of all prescription & non-prescription drugs, dietary supplements, & herbal products (include indication, dose, and directions for each)
 - Allergies
 - Environmental and lifestyle factors
 - Immunizations
 - Medical devices
 - Social history
 - Current and resolved medical conditions
 - Family history
 - Primary HCP and contact information
- Clinical Encounter:
 - List of medications addressed during encounter, assessing safety and efficacy of each
 - Assessment of potential drug therapy problems:
 - Appropriate indication
 - Adverse effects/toxicity
 - Cost efficacy
 - Appropriate dosing
 - Adherence
 - Goals of therapy
 - Education, instructions, and resources delivered to member
 - Written plan of goals, actions to resolve issues, follow up, and referrals (if needed)
 - MTM pharmacist's communications to member's other health care providers
 - MTM pharmacist's name and credentials
- Billing
 - Clinical encounter date of service
 - Member location if using interactive video
 - Time spent face-to-face with member
 - Date of documentation

Before the MTM Encounter

MTM provider will set up an appointment with the member. The time required to prepare for the encounter is not billable including:

- Verify member's ND Medicaid eligibility
- Request/receive MTM SA approval
- Complete chart review
- Identify potential drug therapy problems
- Print anticipated education handouts and visit documentation
- Review treatment guidelines

- Place reminder call(s)

Special considerations for Transition of Care MTM:

- Schedule within 7 days of discharge
- Obtain discharge information before encounter

During the MTM Encounter

MTM provider should be fully prepared to conduct the MTM encounter at the time of the member's appointment

- Verify member's identity
- Prepare Personal Medication List (PML) and Patient Visit Summary
- Provide pertinent materials to member to assist in managing condition(s)
- Document evaluation of drug therapy, recommended interventions, and education
- Schedule follow-up appointments (as needed) to ensure adherence to medication plan and determine progress of set goals

Following the MTM Encounter

All written and verbal contact must be documented in the member's electronic MTM record. The time required to document the MTM encounter is not billable.

MTM provider must provide the following communication within 7 days of the visit:

- To the member:
 - Patient Visit Summary including:
 - Personal Medication List (active medication record)
 - Goals and action plan
- To all relevant HCPs (Primary care, Specialists).
 - HCP Visit Summary
 - Brief explanation of program (optional)
 - Contact prescriber by phone if immediate attention required

MTM provider must make three attempts at a follow-up phone call 2 to 4 weeks after the initial MTM encounter and document a summary of the call.

If unable to reach member, document each call attempt in the electronic record, including date, time, and outcome of contact.

Reimbursement

CPT Code	CPT code description	Reimbursement
99605	8 to 15 minutes face-to-face counseling, new patient	\$70
99606	8 to 15 minutes face-to-face counseling, established patient	\$25
99607	8 to 15 additional minutes face-to-face counseling, new or established	\$25

99605 reimbursement includes required follow-up phone call to member

Examples:

- 8 to 22 minutes
 - New: Bill 1 unit of 99605 = \$70
 - Established: Bill 1 unit of 99606 = \$25
- 23 to ≥30 minutes
 - New: Bill 1 unit of 99605 and 1 unit of 99607 = \$95
 - Established: Bill 1 unit of 99606 and 1 unit of 99607 = \$50

Limits

Only consultation time with the Medicaid MTM member should be considered for time billed for reimbursement by MTM CPT codes:

- Face-to-Face (including telehealth) visit is required for new patients (CPT 99605)
- Maximum of 4 MTM encounters per 365 days
- May request additional visits within the 365-day period or to exceed the 365-day period via service authorization

99605: One unit per member in a 365-day period

99606: Up to three units per member in a 365-day period

99607: Up to one unit per member per date of service

Not allowed for reimbursement:

- Group visits
- Preparation time
- No-show appointments
- Follow-up/reminder calls (not separately reimbursed)

Allowed for reimbursement

- Visits with family and/or caregiver(s) in attendance
- Synchronous telehealth visits with real-time audio/visual conferencing
- Audio-only telephone visits allowed for established patients only (CPT 99606 and 99607)

MTM Patient Identification Worksheet

Adherence Related Problems

- Patient is non-adherent, and pharmacist can help with identifying adherence barriers to recommend/provide appropriate adherence strategies and tools:
 - Setting up pill boxes
 - Reminders
 - Arranging transportation
- Patient needs help navigating side effects (not limited to these classes):
 - HIV/AIDs
 - Chemotherapy
 - Immunosuppression
 - Hepatitis C antiviral
- Patient is experiencing one of the following needs for more time/resources:
 - Language barriers
 - Cultural differences
 - Limited health literacy
- Resources
 - [Non-emergent transportation](#) to and from the pharmacy or clinic for medical care is a covered service and coordinated through the human service zone
 - [Health Literacy Tools for Providers of Medication Therapy Management | Agency for Healthcare Research and Quality \(ahrq.gov\)](#)
 - [Explicit and Standardized Prescription Medicine Instructions | Agency for Healthcare Research and Quality \(ahrq.gov\)](#)
 - POS identification: 88 – DUR Reject Error - Underutilization

Deprescribing Opportunities

- Patient is on a medication that is not indicated for long-term use, and an opportunity to deprescribe has been identified, such as:
 - Proton Pump Inhibitor
 - Benzodiazepine
 - Hypnotic (Z-sleeper)
 - Muscle Relaxant
 - Opioid
- Patient is experiencing an interaction or side effects and needs medication change

Transition of Care

- Patient is taking 2+ medications and has started managing their own medications within past 2 months, such as:
 - Discharge to home from hospital
 - Discharged to home from skilled nursing facility
 - Released from prison/half-way housing
 - Discharged to home from psychiatric residential treatment facility

Safer Sex Practices

- Patient has risk of unintended pregnancy or sexually transmitted infections, and pharmacist has provided education, resources, and referrals, such as:
 - Resources: brochures, posters, provider guides for sexual health services
 - Prevention Supplies: condoms, dental dams, lubricant, safer sex kits
 - Referrals: Sexually Transmitted Infections (STI) testing
- Resources
 - [Sexually Transmitted Infection \(STI\) Program](#)
 - [HIV Testing](#)
 - [HIV PrEP | Health and Human Services North Dakota](#)
 - [HIV, STI, and Viral Hepatitis Brochures and Resources](#)

Asthma or COPD

- Patient has medication related problem or lack of disease control such as:
 - Using > 3 rescue (short-acting beta₂-agonist) inhalers per year
 - Using rescue nebulizers 3 or more times per day
 - Missing controller medication (e.g., steroid, LAMA)

Diabetes

- Patient has medication related problem or lack of disease control such as:
 - A1c or time in range (TIR) outside of goal (e.g., A1c > 7, TIR < 70%)
 - Has a diabetes-related complication
 - Has a comorbid condition

Persons Who Inject Drugs (PWID)

- Patient that injects drugs is provided resources, such as:
 - Disease prevention strategy education
 - Referral to Syringe Service Program
 - Substance use treatment motivational interviewing
 - Referral to substance use disorder treatment
- Resources
 - [Syringe Service Programs \(SSP\)](#)

Guideline Based Therapy

- Pharmacist has identified drug therapy that is not optimal (based on guidelines, symptom management, side effects, risk profile, etc.), such as:
 - Medication is not indicated
 - Medication is missing from therapy
 - Medication is being used to treat a side effect of another medication
 - Duplicate therapy
 - Lifestyle modifications related to disease state management
- Resources
 - Guideline Based Therapy: POS identification
 - 39 – Inv Diagnosis Cde -Diagnosis Not Covered
 - 70 – Product / Service Not Covered – Age Not Covered
 - 88 – DUR Reject Error – Drug – Disease Interaction

Increased Risk of Overdose

- Patient has an increased risk of overdose, such as:

High dose risk factors

- Recently started a long-acting opioid
- Taking a high dose of opioids (e.g., > 50 Morphine Milliequivalents (MME)/day)
- Prescription Drug Monitoring Program (PDMP) shows a high NarxCare Score (e.g., > 650)

Polypharmacy risk factors:

- Using multiple medications that cause CNS depression (e.g., antipsychotics, hypnotics, muscle relaxant, benzodiazepine, opioid)
- Pharmacy or doctor shopping behaviors (e.g., > 4 pharmacies or >7 prescribers within past 365 days)

- Resources
 - High Risk Medication: POS identification
 - 76- Plan Limitations Exceeded – Morphine Milligram Equivalents
 - 79 – Refill Too Soon
 - 79 – Refill Too Soon – Accumulation Refill Too Soon

MTM Encounter Guidance

MTM Encounter: Not All-Inclusive

Pharmacists providing medical services are expected to establish an open, collaborative working relationship with members' primary and treating health care providers (HCP)

MTM provider will assess relevant factors influencing disease control and medication use:

- Medication appropriateness (based on symptoms, labs, current guidelines, etc.)
- Medication use problems (adherence issues, administration technique, etc.)
- Lifestyle and quality of life (triggers, social history, environment, etc.)
- Personal and family medical history
- Safety and efficacy of medications

MTM provider will discuss with the member as applicable:

- Understanding of disease state(s)
- How medications are to be taken and purpose of medications
- Benefits, risks, and adverse reactions of drug therapy
- Goals and expectations of drug therapy, including functional status
- Safe storage and disposal of medications
- Pharmacological and non-pharmacological treatment alternatives
- Potential referrals

MTM Follow-Up Phone Call

During this phone call, the MTM provider should:

- Assess adherence addressing adherence barriers
- Evaluate member's understanding of medication regimen
- Identify additional side effects, interactions, and treatment concerns

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